Records Section and the Personnel Administration Division Officer responsible for these records indicated that the DD Form 1380 is not required to be maintained in the outpatient health record and that it is usually destroyed.

[0015] Due to insufficient training of medical records personnel and/or lack of information collected at the point of care/point of injury, medical information is lost, not captured or destroyed. If there were a means by which to capture this information in a computerized format, there would be 1) an increase in the efficacy of the information, 2) tracking capability for epidemiological information, and 3) immediate access to medical information for command and control based on the computerized clinical encounters.

[0016] The next part of the analysis was conducted by practical experience, observation and interviews related to the skills training of the medics. In combat maneuver battalions, the qualifications of the combat medics vary depending on educational background, experience and motivation. Medics are provided initial training for responding to combat related injuries and rudimentary clinical documentation. It is generally left up to the unit of assignment to provide further skills training for soldiers. As a soldier's rank increases, he is sent to more advanced medical training or Special Forces medical training. The more skilled medics, physicians and physician's assistants are responsible for training the lesser skilled medics during scheduled training times and through practical experience. Of the combat medics observed and interviewed, they typically lacked the sufficient skills to respond to real world injuries and sick call screening, unless they had been assigned to a Medical Center or health clinic during the early part of their career. The medics that were directly assigned to combat arms units from their initial training had extreme skills deficiencies.

[0017] The focus for training in the combat arms units was on vehicle maintenance. It was expected that medics were highly trained prior to being assigned to the unit. In addition, medics received training one day per week on medical skills and/or training on how to pass the Expert Field Medical Badge training. This was complimentary to training medics to a high level of proficiency in field medicine for combat injuries, but lacked severely in training medics on how to provide treatment for sick call or non-combat related injuries. One way to address this would be to have a skills trainer or training device that could help to facilitate interactive training for combat medics and Special Forces medics.

[0018] The next part of the analysis was accomplished through practical experience, observation and literature research and related to medical supply. When in a training or deployed environment, Class VIII medical supplies are generally ordered after a manual inventory of supplies is conducted. When communications become available or through sending supply requests on notepads, the supplies are ordered. Of all of the medics interviewed, none were documenting the medical supplies that were used for training, deployments or for sick call in field environments. At the battalion aid station, supplies were inventoried and reordered monthly or as needed for sick call. The medical supplies in the combat load were inventoried either annually or during a major deployment as necessary.

[0019] During both the training and deployed environments, medics had little to no communications available to them to request resupply and had to rely on supply requests written on notepads and in some cases did not get resupplied until returning to home station. This form of resupply can lead to a decrease in the combat readiness of the medics limiting their ability to continue to provide medical treatment to the soldiers at the initial point-of-care.

[0020] This last part of the analysis was accomplished through practical experience and observation and related to the security of the medical information. The security of medical information for the combat medic is limited to the physical security of health care information by the combat medic.

[0021] Most combat medics carry a leader's book which contains some soldier information, medical information such as current medications, allergies and possibly some medical history. Medics also are required to capture information on DD Form 1380. When they capture the information, they remove an onion skin (protective paper) and maintain a copy of each encounter in the Field Medical Card Book. Each encounter not only contains medical information but also the soldier's demographics and unit information. At the battalion aid station, medical personnel maintain the outpatient health records in filing cabinets.

[0022] The security of medical information at the point of care at the level of the combat medic is inadequate for today's emerging health care security standards and could provide potentially vital tactical information to hostile forces if lost or if the medic is captured. The current field medical cards and accompanying book that maintains the copies of the field medical cards can not easily be torn up, nor could they be easily burned or destroyed. If the information is in computerized format on a handheld device the information could be made more secure and even easily erased to preclude the information getting into the hands of anyone but the intended provider.

[0023] On the backdrop of the above analysis, there is a Presidential Review Directive 5 that mandates development of a standardized, integrated and seamless system of medical command and control for the military medical community within The Global Command and Control System (GCCS) to include an individually carried device.

[0024] The Department of Defense is currently funding the Composite Health Care System II (CHCS II) program intended to produce a clinical information and medical information management support system for military peacetime health care facilities as a follow-on to the current CHCS I system which currently provides medical administrative information management, ancillary services support and order entry for both inpatient and outpatient care in most fixed DOD health care facilities. While CHCS II is intended as a point of care system to support most health care provider information processing needs, it is limited by placement of desktop PCs or location of laptop PC LAN "plug-ins". To the best of the present inventor's knowledge, a truly portable, pocket-sized PC tool is not being provided by the CHCS II system.

[0025] DOD (HA) has also designated a program manager for deployable military health care information processing systems development. The Theater Medical Information Program (TMIP) is charged with identifying requirements and developing deployable medical information systems for the DOD. As yet, the TMIP has not fielded a point of